mechanism of his heart. The child with heart disease should never be exposed to ridicule or reprimands. If a child with heart disease needs correction, the teacher should take the child privately aside and talk to him. The teacher should watch and see that the child with heart disease is given his rest period at noon. Special arrangements should be made for tardy slips when the child has to walk to school and where buildings are far apart. In severe cases, programs should be lightened. The health cards should be inspected and checked to see whether the children have infected tonsils that have been recommended for removal or whether any other chronic infections are present.

A very warm or drafty classroom is detrimental to a child with heart disease because this type of child is very susceptible to colds. Every cold means more infection and an infection may mean future weakening of the heart muscle. If a child with heart disease looks ill, the teacher should investigate the circumstances, send the child home and notify the school physician or the school nurse.

In all that you do, try to avoid the suggestion of invalidism. It is a great mistake to make any child too heart conscious, as he may become a chronic neurotic when he becomes an adult and be a burden to himself and to society.

It is far more important to pay attention to the physical condition of the child with heart disease than to his education.

VOLUNTARY HOSPITAL INSURANCE PLANS APPROACH ONE MILLION MEMBERS*

Nonprofit Plans for Budgeting Hospital Bills Report Threefold Increase in Membership and Greater Financial Stability During Past Year

Voluntary hospital insurance plans, by which workers and their families budget their hospital bills through monthly payments equal to two or three cents a day, reported an enrollment of approximately 900,000 subscribers April 1, 1937. This is to be compared with an estimated enrollment of 800,000 persons a year ago.

The membership is distributed among seventy-five different organizations in various parts of the United States, including New York City, Washington, D. C., Chicago, Cleveland, Minneapolis, St. Paul, New Orleans, Sacramento, Buffalo, Rochester, N. Y., Syracuse, Newark, Dallas, Houston, as well as smaller communities in the southern and western states.

Most of the growth has occurred among nonprofit free-choice plans of the type sponsored and recommended by the American Hospital Association. Thirty-three such associations have enrolled 750,000 members in eighteen different states, where they are supervised and regulated by the state departments of insurance or are organized under the general laws covering nonprofit corporations. Plans operated by individual hospitals and private promoters and industrial enterprises report approximately 125,000 subscribers, which is essentially the same number as were enrolled twelve months previously. These figures do not include an additional 75,000 enrolled by industrial firms or labor unions exclusively for their own membership, or the various plans of contract practice or insurance covering both hospital and medical services.

During the past three years many plans have been under discussion, but not actually placed in operation. The files of the American Hospital Association contain information of at least one hundred such plans which were discontinued before they reached the stage of actually enrolling subscribers. Four single-hospital plans have been discontinued because of local professional opposition of lack of community interest. In addition, a number of privately owned plans have stopped their activities because of conflicts with insurance law requirements or difficulties of interesting prospective subscribers.

In no instance has a nonprofit free-choice hospital service association been discontinued. The enrollment in these organizations is increasing from month to month, hospitals have been paid promptly for services to subscribers, and reserves have been established by initial deposit or accumulation of earnings to meet the requirements of insurance departments or sound business policy.

Voluntary hospital care insurance is not a panacea for the problems of hospital finance; moreover, hospital insurance is not a complete answer to the public's request for a plan of budgeting the costs of sickness. Experience has demonstrated, however, that hospital service plans which are established with primary emphasis upon public welfare have also been economically sound in their relations with subscribers and hospitals.

During the year 1934 the insurance laws of the State of New York were amended to permit the formation of nonprofit hospital service corporations, to be governed by special regulations of the departments of insurance and social welfare. The following year, similar acts were enacted by the legislatures of Alabama, California and Illinois, and in 1937, permissive legislation has been passed in the states of Georgia and Maryland which place nonprofit hospital service corporations directly under the supervision of the departments of insurance.

The American Hospital Association does not recommend the establishment of hospital service associations unless they meet the standards of the Council and trustees of the Association established in February, 1933. These standards are: emphasis on public welfare; nonprofit sponsorship and control; free choice of hospital by subscriber; limitation of benefits to hospital service; representation of community and professional interests; economic and actuarial soundness; dignified promotion and management.

The largest membership has been reached by Associated Hospital Service, Incorporated, of New York, which enrolled more than 350,000 subscribers during the first two years of its life ended May 1, 1937. Next largest is the plan conducted in Minneapolis and St. Paul, which reports 85,000 after four years' activity. Other growing plans have enrollment as follows: Rochester, New York, 65,000; Cleveland, 50,000; New Orleans, 40,000; Washington, D. C., 35,000; Durham, North Carolina, 26,000; Chapel Hill, North Carolina, 23,000; Newark, New Jersey, 20,000; Sacramento, California, 16,000.

April 1 (1937) Enrollment of Non-Profit Hospital Service Plans Which Have Been in Operation Twelve Months or Longer

Location of Headquarters	*Employed Subscribers*	*Dependents*	*Total*
Birmingham, Alabama	5,632	4,476	10,108
Sacramento, California	10,454	5,227	15,681
San Jose, California	557	550	1,107
Norwalk, Connecticut	3,596	1,041	4,637
Wilmington, Delaware	4,715	2,328	7,043
Washington, D. C.	35,000	none	35,000
Ashland, Kentucky	3,765	2,714	6,479
New Orleans, Louisiana	13,378	26,298	39,676
St. Paul, Minnesota	40,429	42,951	83,380
St. Louis, Missouri	7,013	none	7,013
Newark, New Jersey	14,502	5,725	20,227
Geneva, New York	830	130	960
New York City	186,143	97,316	283,459
Rochester, New York	35,129	29,015	64,144
Syracuse, New York	10,796	none	10,796
Chapel Hill, North Carolina	15,000	7,975	22,975
Durham, North Carolina	13,500	13,000	26,500
Cleveland, Ohio	44,401	5,833	50,234
Easton, Pennsylvania	3,200	3,100	6,300
Kingsport, Tennessee	2,349	4,439	6,788
Norfolk, Virginia	4,126	2,313	6,439
Richmond, Virginia	2,887	none	2,887
Bluefield, West Virginia	4,094	6,485	10,579
Charleston, West Virginia	3,610	6,173	9,783

Other nonprofit hospital service associations formed since April 1, 1936, are located at Oakland, California; New Haven, Connecticut; Chicago and Peoria, Illinois; Albany, Buffalo, Jamestown and Utica, New York; and Akron, Ohio.

* Issued by C. Rufus Rorem, Director, Committee on Hospital Service, American Hospital Association, Chicago.